SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*44511*
Company Tracking Number:	*AR GVAPBER*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American Heritage Life Insurance Company

Product Name: Group Accident Benefit Enhancement Rider	SERFF Tr Num: ALST-126447073	State: Arkansas
TOI: H02G Group Health - Accident Only	SERFF Status: Closed-Approved-Closed	State Tr Num: 44511
Sub-TOI: H02G.000 Health - Accident Only	Co Tr Num: AR GVAPBER	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Angie Redden, Jennifer Aiello, Lynn Bautista, Leslie Blandford, Juli Clausen	Disposition Date: 01/08/2010
	Date Submitted: 01/08/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Association, Other
Filing Status Changed: 01/08/2010	Explanation for Other Group Market Type: Labor Unions
	State Status Changed: 01/08/2010
Deemer Date:	Created By: Jennifer Aiello
Submitted By: Jennifer Aiello	Corresponding Filing Tracking Number:

Filing Description:

Re: American Heritage Life Insurance Company, NAIC Number: 60534
Group Accident Policy Forms GVAPBER and GVACBER

We submit the above referenced forms for your review and approval. These forms are new and do not replace any

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
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Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

forms currently approved by your department. They will be used with Group Voluntary Accident Policy, GVAP1(AR) et al, which was approved by your department on April 22, 2002 (no filing # available). A copy of the approval letter is attached.

These riders provide benefits when an insured receives a covered loss due to an accidental injury. Sample pages 3-3B containing the benefit amounts for 1 unit of coverage are included for your information.

Any logo, officer signature or Home Office address and telephone number that appears on these forms is subject to change.

If you have any questions, feel free to call me at (904) 992-3045. I can also be reached by email at aredden@allstate.com.

Company and Contact

Filing Contact Information

Jennifer Aiello, Filing Analyst
Attn: Legal/Compliance
1776 American Heritage Life Drive
Jacksonville, FL 32224-9983

jhop4@allstate.com
904-992-2541 [Phone]
904-992-2975 [FAX]

Filing Company Information

American Heritage Life Insurance Company
ATTN: Legal/Compliance
1776 American Heritage Life Drive
Jacksonville, FL 32224-9983
(904) 992-1776 ext. [Phone]

CoCode: 60534
Group Code: 8
Group Name: Allstate
FEIN Number: 59-0781901

State of Domicile: Florida
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$40.00
Retaliatory?	No
Fee Explanation:	$20 per misc. form X 2 forms = $40
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
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Product Name:	*Group Accident Benefit Enhancement Rider*		
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American Heritage Life Insurance Company	$40.00	01/08/2010	33376428

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
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Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/08/2010	01/08/2010

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*44511*
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TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/08/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*44511*
Company Tracking Number:	*AR GVAPBER*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Approval letter for GVAP1(AR) et. al	Approved-Closed	Yes
Supporting Document	Sample Specifications pages	Approved-Closed	Yes
Form	Group Accident Benefit Enhancement Rider	Approved-Closed	Yes
Form	Group Accident Benefit Enhancement Rider	Approved-Closed	Yes

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*44511*
Company Tracking Number:	*AR GVAPBER*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: GVAPBER

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/08/2010	GVAPBER	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Group Accident Benefit Enhancement Rider	Initial		52.200	GVAPBER Policy Rider.pdf
Approved-Closed 01/08/2010	GVACBER	Certificate Amendment, Insert Page, Endorsement or Rider	Group Accident Benefit Enhancement Rider	Initial		52.400	GVACBER Certificate Rider.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

GROUP ACCIDENT BENEFIT ENHANCEMENT RIDER

This rider is issued in consideration of the rider premium and the written request for this rider. Benefits are paid in addition to the benefits of the policy to which it is attached. Benefits are subject to all of the terms, conditions and provisions of the policy. All terms defined and used in the policy apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Coma. Means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

General Anesthesia. Means a process that produces loss of consciousness, in addition to pain relief and paralysis of skeletal muscle over the entire body, by the administration of anesthetic drugs and is used during major and other invasive surgical procedures.

Physical Therapist. Means a licensed specialist in physical therapy. The term “Physical Therapist” does not include: a chiropractor; any covered person; or any spouse, parent, brother, sister or child of a covered person.

Policy. Means the policy to which this rider is attached.

Rider Date. Means the effective date of coverage under this rider. The rider date is the policy date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our policy dating rules in effect at the time this rider is issued.

BENEFITS

We pay the following benefits for expenses incurred as a result of an injury to a covered person caused by an accident occurring while this rider is in force. All treatment must be performed on the recommendation of or under the supervision of, a physician. Any loss or expense not stated in the BENEFITS provision of this rider is not covered under this rider. Treatment must be received in the United States or its territories.

A. Hospital Admission Benefit. This benefit is payable only for accidents occurring 12 months after the covered person has been continuously covered by this rider. We pay the amount shown on page 3B for the first hospital confinement during a calendar year, provided a benefit is paid under the Hospital Confinement Benefit in the policy. The covered person must be confined to a hospital within 3 days after the accident. This benefit is payable only once per covered person per hospital confinement per calendar year.

B. Lacerations Benefit. We pay the amount shown on page 3B if a covered person receives treatment for 1 or more lacerations (cuts) within 3 days after the accident. This benefit is payable only once per covered person per calendar year.

C. Burns Benefit. We pay the amount shown on page 3B if a covered person receives treatment for 1 or more burns, other than sun burns, within 3 days after the accident. This benefit is payable only once per covered person per accident.

D. Skin Graft Benefit. We pay the amount shown on page 3B if a covered person receives a skin graft for a burn for which a benefit is paid under the Burns Benefit. The skin graft must be performed within 90 days after the accident. This benefit is payable only once per covered person per accident.

E. Brain Injury Diagnosis Benefit. We pay the amount shown on page 3B upon the first diagnosis of 1 of the following traumatic brain injuries by a covered person: concussion, cerebral laceration, cerebral contusion, or intracranial hemorrhage. The covered person must be first treated by a physician within 3 days after the accident.

The covered traumatic brain injury must be diagnosed within 30 days after the accident by computed tomography (CT) scan, magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission tomography (PET) scan, or X-ray. This benefit is payable only once per covered person.

F. Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) Benefit. We pay the amount shown on page 3B if a covered person receives a CT scan or MRI within 180 days after the accident. The covered person must be first treated by a physician within 30 days after the accident. This benefit is payable only once per covered person per accident per calendar year.

G. Paralysis Benefit. We pay the amount shown on page 3B if a covered person receives a spinal cord injury resulting in the complete and permanent loss of use of 2 or more limbs as a result of an injury. Paralysis must be confirmed by the attending physician within 3 days after the accident and have a duration of at least 90 consecutive days. This benefit is payable only once per covered person.

H. Coma with Respiratory Assistance Benefit. We pay the amount shown on page 3B if a covered person is in a coma. This benefit is payable only once per covered person.

I. Open Abdominal or Thoracic Surgery Benefit. We pay the amount shown on page 3B if a covered person undergoes open abdominal or thoracic surgery for internal injuries within 3 days of the accident. We pay this benefit even if no surgical repair is required.

If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

J. Tendon, Ligament, Rotator Cuff or Knee Cartilage Surgery Benefit. We pay the amount shown on page 3B if a covered person undergoes a surgical procedure to repair an injury to a tendon, ligament, rotator cuff or knee cartilage. The injured site must be torn, ruptured, or severed and the surgical procedure must be performed by a physician within 180 days after the accident.

If exploratory surgery using arthroscopy is performed and no surgical repair is required then we will pay the amount shown on page 3B. If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation and we will pay the amount for the procedure with the largest dollar amount benefit.

K. Ruptured Disc Surgery Benefit. We pay the amount shown on page 3B if a covered person undergoes a surgical procedure to repair a ruptured disc of the spine. The ruptured disc must be diagnosed and the surgical procedure must be performed by a physician within 180 days after the accident.

If 2 or more surgical procedures are performed through the same incision or entry point, they are considered 1 operation.

L. Eye Surgery Benefit. We pay the amount shown on page 3B for surgery or removal of a foreign object from the eye of a covered person. The procedure must be performed by a physician within 90 days after the accident. An examination with or without anesthesia is not considered surgery. This benefit is payable only once per covered person per accident.

M. General Anesthesia Benefit. We pay the amount shown on page 3B if a covered person received general anesthesia administered by a nurse anesthetist or physician for surgery required to treat an injury provided a benefit is paid for the surgery under the Surgery Benefit of the policy. The surgery must be performed by a physician within 180 days after the accident.

N. Blood and Plasma Benefit. We pay the amount shown on page 3B if a covered person receives a blood or plasma transfusion within 3 days after an accident. This benefit is payable only once per covered person per accident.

O. Appliance Benefit. We pay the amount shown on page 3B if a covered person receives 1 of the following medical appliances prescribed by a physician as an aid in personal locomotion or mobility: wheelchair, crutches, or walker. The use of a medical appliance must begin within 90 days after the accident. This benefit is payable only once per covered person per accident.

P. Medical Supplies Benefit. We pay the amount shown on page 3B for over-the-counter medical supplies purchased for a covered person provided a benefit is paid for the accident under the Medical Expenses Benefit in the policy. The supplies must be purchased within 90 days after the accident. We pay this benefit once per covered person per accident.

Q. Medicine Benefit. We pay the amount shown on page 3B per accident for prescription or over-the-counter medicine purchased for a covered person provided a benefit is paid for the accident under the Medical Expenses Benefit in the policy. The medicine must be purchased within 90 days after the accident. We pay this benefit once per covered person per accident.

R. Prosthesis Benefit. We pay the amount shown on page 3B for a prosthetic arm, leg, hand, foot or eye prescribed by a physician to replace an arm, leg, hand, foot or eye that a covered person loses as a direct result of an accident. This benefit is paid only if a benefit is paid for the loss of an arm, leg, hand, foot or eye under the Dismemberment Benefit in the policy. The prosthetic device must be received within 180 days after the accident. This benefit is payable only once per covered person per accident.

S. Physical Therapy Benefit. We pay the amount shown on page 3B per day for physical therapy treatment received by a covered person when prescribed by a physician for an injury, provided a benefit is paid under the Medical Expenses Benefit in the policy. We pay for 1 physical therapy treatment per day for up to a maximum of 6 treatments per accident per covered person. Chiropractic services are excluded.

Physical therapy must be for injuries sustained in an accident and must:
1. begin within 90 days after the accident; and
2. take place no longer than 6 months after the accident.

This benefit is not payable for the same visit for which the Accident Follow-Up Treatment Benefit is paid.

T. Rehabilitation Unit Benefit. We pay the amount shown on page 3B per day if a covered person is confined to a rehabilitation unit as a result of an injury, provided that the covered person has been hospital confined immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days on which the Hospital Confinement Benefit in the policy is paid.

U. Non-local Transportation Benefit. We pay the amount shown on page 3B per trip for non-local treatment of a covered person at a hospital or other specialized freestanding treatment center prescribed by a physician when the same or similar treatment cannot be obtained locally. "Non-local" means a one-way trip of 100 miles or more from the covered person's home to the nearest treatment facility. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable up to 3 times per accident. Transportation by ground or air ambulance is not covered under this benefit.

V. Family Member Lodging Benefit. We pay the amount shown on page 3B per day for the lodging of 1 adult family member of the covered person's family to be with the covered person when a covered person is confined in a non-local hospital or other specialized freestanding treatment center for treatment. This benefit is payable for up to 30 days for each accident.

This benefit is only payable if the Non-local Transportation Benefit is paid. This benefit will not be paid if the family member lives within 100 miles one-way of the treatment facility.

W. Post-Accident Transportation Benefit. We pay the amount shown on page 3B if a covered person is hospital confined for at least 3 consecutive days due to an injury resulting from an accident which occurs more than 250 miles from his or her place of residence and the covered person is brought home by a common carrier.

For the purposes of this rider, a common carrier means a method of transport with defined published routes, time schedules and rates approved by regulators. These include public airlines, railroads, and bus lines. Travel to the place of residence must take place within 48 hours following discharge from the hospital. This benefit is payable for the injured covered person only, and only if the Hospital Confinement Benefit in the policy is paid. This benefit is payable only once per covered person per calendar year.

X. Accident Follow-Up Treatment Benefit. We pay the amount shown on page 3B per day for follow-up treatment received by a covered person provided a benefit is paid under the Medical Expenses Benefit in the policy. We pay for 1 follow-up treatment per day for up to a maximum of 2 treatments per covered accident per covered person.

Treatments must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must be for injuries sustained in a covered accident and must:
1. begin within 90 days after the accident; and
2. take place no longer than 6 months after the accident.

This benefit is not payable for the same visit for which the Physical Therapy Benefit is paid.

LIMITATIONS AND EXCLUSIONS

The Limitations and Exclusions section of the policy applies to this rider.

TERMINATION

This rider terminates at the earliest of:
1. the date the group policy is canceled; or
2. the last day of the period for which any required premium payments were made; or
3. the last day the insured employee is in active employment, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
4. the date the insured employee is no longer in an eligible class; or
5. the date the insured employee's class is no longer eligible.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

AMERICAN HERITAGE LIFE INSURANCE COMPANY

1776 American Heritage Life Drive, Jacksonville, Florida 32224

GROUP ACCIDENT BENEFIT ENHANCEMENT RIDER

This rider is issued in consideration of the rider premium and the written request for this rider. Benefits are paid in addition to the benefits of the certificate to which it is attached. Benefits are subject to all of the terms, conditions and provisions of the certificate. All terms defined and used in the certificate apply to this rider unless otherwise provided in this rider.

DEFINITIONS

Certificate. Means the certificate to which this rider is attached.

Coma. Means a continuous state of profound unconsciousness which lasts 7 or more consecutive days as a result of a covered accident. A coma is characterized by an absence of spontaneous eye movements, response to painful stimuli and vocalization. The condition must require intubation for respiratory assistance. Medically induced comas are excluded.

General Anesthesia. Means a process that produces loss of consciousness, in addition to pain relief and paralysis of skeletal muscle over the entire body, by the administration of anesthetic drugs and is used during major and other invasive surgical procedures.

Physical Therapist. Means a licensed specialist in physical therapy. The term “Physical Therapist” does not include: a chiropractor; any covered person; or any spouse, parent, brother, sister or child of a covered person.

Rider Date. Means the effective date of coverage under this rider. The rider date is the certificate date, unless this rider is applied for at a later date. If this rider is applied for at a later date, the rider date is the effective date assigned by our home office in accordance with our coverage dating rules in effect at the time this rider is issued.

BENEFITS

We pay the following benefits for expenses incurred as a result of an injury to a covered person caused by an accident occurring while this rider is in force. All treatment must be performed on the recommendation of or under the supervision of, a physician. Any loss or expense not stated in the BENEFITS provision of this rider is not covered under this rider. Treatment must be received in the United States or its territories.

A. Hospital Admission Benefit. This benefit is payable only for accidents occurring 12 months after the covered person has been continuously covered by this rider. We pay the amount shown on page 3B for the first hospital confinement during a calendar year, provided a benefit is paid under the Hospital Confinement Benefit in the certificate. The covered person must be confined to a hospital within 3 days after the accident. This benefit is payable only once per covered person per hospital confinement per calendar year.

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The covered traumatic brain injury must be diagnosed within 30 days after the accident by computed tomography (CT) scan, magnetic resonance imaging (MRI), electroencephalogram (EEG), positron emission tomography (PET) scan, or X-ray. This benefit is payable only once per covered person.

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M. General Anesthesia Benefit. We pay the amount shown on page 3B if a covered person received general anesthesia administered by a nurse anesthetist or physician for surgery required to treat an injury provided a benefit is paid for the surgery under the Surgery Benefit of the certificate. The surgery must be performed by a physician within 180 days after the accident.

N. Blood and Plasma Benefit. We pay the amount shown on page 3B if a covered person receives a blood or plasma transfusion within 3 days after an accident. This benefit is payable only once per covered person per accident.

O. Appliance Benefit. We pay the amount shown on page 3B if a covered person receives 1 of the following medical appliances prescribed by a physician as an aid in personal locomotion or mobility: wheelchair, crutches, or walker. The use of a medical appliance must begin within 90 days after the accident. This benefit is payable only once per covered person per accident.

P. Medical Supplies Benefit. We pay the amount shown on page 3B for over-the-counter medical supplies purchased for a covered person provided a benefit is paid for the accident under the Medical Expenses Benefit in the certificate. The supplies must be purchased within 90 days after the accident. We pay this benefit once per covered person per accident.

Q. Medicine Benefit. We pay the amount shown on page 3B per accident for prescription or over-the-counter medicine purchased for a covered person provided a benefit is paid for the accident under the Medical Expenses Benefit in the certificate. The medicine must be purchased within 90 days after the accident. We pay this benefit once per covered person per accident.

R. Prosthesis Benefit. We pay the amount shown on page 3B for a prosthetic arm, leg, hand, foot or eye prescribed by a physician to replace an arm, leg, hand, foot or eye that a covered person loses as a direct result of an accident. This benefit is paid only if a benefit is paid for the loss of an arm, leg, hand, foot or eye under the Dismemberment Benefit in the certificate. The prosthetic device must be received within 180 days after the accident. This benefit is payable only once per covered person per accident.

S. Physical Therapy Benefit. We pay the amount shown on page 3B per day for physical therapy treatment received by a covered person when prescribed by a physician for an injury, provided a benefit is paid under the Medical Expenses Benefit in the certificate. We pay for 1 physical therapy treatment per day for up to a maximum of 6 treatments per accident per covered person. Chiropractic services are excluded.

Physical therapy must be for injuries sustained in an accident and must:
1. begin within 90 days after the accident; and
2. take place no longer than 6 months after the accident.

This benefit is not payable for the same visit for which the Accident Follow-Up Treatment Benefit is paid.

T. Rehabilitation Unit Benefit. We pay the amount shown on page 3B per day if a covered person is confined to a rehabilitation unit as a result of an injury, provided that the covered person has been hospital confined immediately prior to being transferred to the rehabilitation unit. This benefit is paid for each day a room charge is incurred, up to 30 days for each covered person per continuous period of rehabilitation unit confinement, for a maximum of 60 days per calendar year. This benefit is not payable for days on which the Hospital Confinement Benefit in the certificate is paid.

U. Non-local Transportation Benefit. We pay the amount shown on page 3B per trip for non-local treatment of a covered person at a hospital or other specialized freestanding treatment center prescribed by a physician when the same or similar treatment cannot be obtained locally. "Non-local" means a one-way trip of 100 miles or more from the covered person's home to the nearest treatment facility. We do not pay for visits to a physician's office or clinic or for services other than actual treatment. This benefit is payable up to 3 times per accident. Transportation by ground or air ambulance is not covered under this benefit.

V. Family Member Lodging Benefit. We pay the amount shown on page 3B per day for the lodging of 1 adult family member of the covered person's family to be with the covered person when a covered person is confined in a non-local hospital or other specialized freestanding treatment center for treatment. This benefit is payable for up to 30 days for each accident.

This benefit is only payable if the Non-local Transportation Benefit is paid. This benefit will not be paid if the family member lives within 100 miles one-way of the treatment facility.

W. Post-Accident Transportation Benefit. We pay the amount shown on page 3B if a covered person is hospital confined for at least 3 consecutive days due to an injury resulting from an accident which occurs more than 250 miles from his or her place of residence and the covered person is brought home by a common carrier.

For the purposes of this rider, a common carrier means a method of transport with defined published routes, time schedules and rates approved by regulators. These include public airlines, railroads, and bus lines. Travel to the place of residence must take place within 48 hours following discharge from the hospital. This benefit is payable for the injured covered person only, and only if the Hospital Confinement Benefit in the certificate is paid. This benefit is payable only once per covered person per calendar year.

X. Accident Follow-Up Treatment Benefit. We pay the amount shown on page 3B per day for follow-up treatment received by a covered person provided a benefit is paid under the Medical Expenses Benefit in the certificate. We pay for 1 follow-up treatment per day for up to a maximum of 2 treatments per covered accident per covered person.

Treatments must be administered by a physician in a physician's office or in a hospital on an outpatient basis and must be for injuries sustained in a covered accident and must:
1. begin within 90 days after the accident; and
2. take place no longer than 6 months after the accident.

This benefit is not payable for the same visit for which the Physical Therapy Benefit is paid.

LIMITATIONS AND EXCLUSIONS

The Limitations and Exclusions section of the certificate applies to this rider.

TERMINATION

This rider terminates at the earliest of:
1. the date the certificate is canceled; or
2. the date the group policy is canceled; or
3. the last day of the period for which any required premium payments were made; or
4. the last day you are in active employment, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision; or
5. the date you are no longer in an eligible class; or
6. the date your class is no longer eligible.

Signed for AMERICAN HERITAGE LIFE INSURANCE COMPANY at its Home Office.

Secretary

President

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*44511*
Company Tracking Number:	*AR GVAPBER*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/08/2010

Comments:

Attachments:

Readability Certification.pdf

Certification of Compliance.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/08/2010

Comments:

Evidence of Insurability and Enrollment Forms AWD4502EAR and AWD4502PAR are used to enroll for the Group Accident Policy/Certificate to which these riders may be attached.

These forms were approved by your department on May 15, 2009 under filing # 42305.

Attachments:

AWD4502EAR.pdf

AWD4502PAR.pdf

		Item Status:	Status Date:
Satisfied - Item:	Approval letter for GVAP1(AR) et. al	Approved-Closed	01/08/2010

Comments:

Attachment:

AR GVA Approval Letter 04.22.02.pdf

		Item Status:	Status Date:
Satisfied - Item:	Sample Specifications pages	Approved-Closed	01/08/2010

Comments:

Attachments:

SERFF Tracking Number:	*ALST-126447073*	*State:*	*Arkansas*
Filing Company:	*American Heritage Life Insurance Company*	*State Tracking Number:*	*44511*
Company Tracking Number:	*AR GVAPBER*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Group Accident Benefit Enhancement Rider*		
Project Name/Number:	*/*		

GVAP1(AR) PAGE 3.pdf

GVAC1(AR) PAGE 3.pdf

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Jacksonville, Florida 32224-6688

To the Policy Review Section, Arkansas Department of Insurance.

I certify that I have carefully reviewed the form(s) listed below and to the best of my knowledge and ability, find that the form(s) meet the minimum reading ease score on the test used.

Form	Score
GVAPBER	52.2
GVACBER	52.4

Date: January 8, 2010

Diane Ierna
Assistant Vice President, Compliance Department

AMERICAN HERITAGE LIFE INSURANCE COMPANY
Jacksonville, Florida 32224-6687

To the Policy Review Section, ARKANSAS Department of Insurance.

CERTIFICATION OF COMPLIANCE

For Filing Including:

GVAPBER
GVACBER

I hereby certify that, to the best of my knowledge and belief, the forms referenced above comply with the applicable provisions of the state of Arkansas.

Date: January 8, 2010

Diane Ierna
Assistance Vice President
Compliance Department

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate
Workplace Division

☐ New Certificate
☐ Change/Increase Certificate #_____

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks

GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc.)	First	M.I.	SEX	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
RESIDENT ADDRESS (Street or P.O. Box)			CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER		EMPLOYER		DATE OF HIRE (MM/DD/YEAR)
HEIGHT / WEIGHT	JOB TITLE		PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)
BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP		

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?

Group Voluntary Accident ☐ Yes ☐ No
Group Voluntary Cancer/Specified Disease ☐ Yes ☐ No
Group Voluntary Hospital Indemnity ☐ Yes ☐ No
Heritage Choice Dental ☐ Yes ☐ No

If "Yes", please complete the following: Qualifying Event _____

Date of Qualifying Event _____ Current Certificate Number _____

Do you currently have any of the following individual products with AHL?

Accident ☐ Yes ☐ No Cancer ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

If you answered "Yes" to any of the products, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

PLEASE COMPLETE FOR PERSONS TO BE INSURED

(Use additional paper if needed.)

Choose Plan(s):				Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Actively At Work*
Accident	Cancer	Hospital	Dental					
					Employee			☐ Yes ☐ No
					Spouse			☐ Yes ☐ No
								N/A
								N/A
								N/A

*Actively at work means that he/she is actively at work now for wage or profit and has worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

Premium/Billing Mode	Case Number	Agent Number	Percentage Credit
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly ☐ Weekly ☐ Other	Employee Number		
Date of Issue _____	Situs State		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

Accident ☐ Yes ☐ No	Base Units_____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Optional Disability Riders for Employee ☐ Off the Job Accident ☐ Off the Job Accident and Sickness ☐ On and Off the Job Accident ☐ On and Off the Job Accident and Sickness	Employee Monthly Salary $ _____	Rider Units _____
Optional Disability Riders for Spouse ☐ On and Off the Job Accident for Insured Spouse* ☐ On and Off the Job Accident and Sickness for Insured Spouse* ***Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.**	Spouse Monthly Salary $ _____	Rider Units _____

Cancer/Specified Disease ☐ Yes ☐ No **(GVCP2)**	Plan _____	☐ Employee Only ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option ☐	Intensive Care Option ☐	Cancer Screening Option ☐
Units				1			

Cancer/Specified Disease ☐ Yes ☐ No **(GVCP3)**	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option ☐	Intensive Care Option ☐	Wellness Benefit Option ☐
Units				1			

Hospital Indemnity ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option ☐	Prescription Drug Option ☐	Disability Rider ☐	Life Rider ☐
Units						1	

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee+One ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No

If "Yes", please enter the date coverage effective _____

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM
EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected. Does not apply to Dental.)

If any of the questions 1-6 below are answered "yes", please list the required health history on the next page.		
Cancer, Hospital Indemnity & Sickness Disability Riders	1. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	☐ Yes ☐ No
Sickness Disability Riders	2a. Has any person to be insured, within the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	☐ Yes ☐ No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
	c. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	☐ Yes ☐ No
	d. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	☐ Yes ☐ No
Cancer & Hospital Indemnity	3a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	☐ Yes ☐ No
	b. If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	☐ Yes ☐ No
	c. Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	☐ Yes ☐ No
Cancer	4. Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thallasemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	☐ Yes ☐ No
Intensive Care Option (Cancer Only) & Hospital Indemnity	5a. Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	☐ Yes ☐ No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
Hospital Indemnity	6. Has any person to be insured, within the last 3 years, been treated for, or been told by a member of the medical profession that he or she has: epilepsy; hepatitis; muscular dystrophy or multiple sclerosis or any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs; paralysis; been counseled for alcohol or drug abuse; or had any medical or surgical procedure recommended but not done at this time?	☐ Yes ☐ No

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

REQUIRED HEALTH HISTORY

***Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

Use this space for any additional explanation of questions 1-6 on page 3. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. **FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. · I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. **· I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, it's subsidiaries or its reinsurers any information. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so. **· I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)

1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224

Allstate
Workplace Division

☐ New Certificate
☐ Change/Increase Certificate #_____

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

Remarks

GENERAL INFORMATION SECTION

Please print with black ink

(Please complete entire section for all coverages)

EMPLOYEE'S NAME Last (Sr, Jr, etc.)	First	M.I.	SEX	SOCIAL SECURITY NUMBER	☐ Married ☐ Single
RESIDENT ADDRESS (Street or P.O. Box)			CITY	STATE	ZIP
BIRTHDATE (MM/DD/YEAR)	RESIDENT PHONE NUMBER		EMPLOYER		DATE OF HIRE (MM/DD/YEAR)
HEIGHT / WEIGHT	JOB TITLE		PLANT OR DIVISION		REHIRE DATE (MM/DD/YEAR)
BENEFICIARY'S NAME (Last, First, M.I.)			RELATIONSHIP		

Are you changing any of your existing coverage due to a qualifying event such as marriage, birth, or adoption?

Group Voluntary Accident ☐ Yes ☐ No
Group Voluntary Cancer/Specified Disease ☐ Yes ☐ No
Group Voluntary Hospital Indemnity ☐ Yes ☐ No
Heritage Choice Dental ☐ Yes ☐ No

If "Yes", please complete the following: Qualifying Event _____

Date of Qualifying Event _____ Current Certificate Number _____

Do you currently have any of the following individual products with AHL?

Accident ☐ Yes ☐ No Cancer ☐ Yes ☐ No Hospital Indemnity ☐ Yes ☐ No

If you answered "Yes" to any of the products, please enter the Policy Number _____

Do you wish to terminate this coverage? ☐ Yes ☐ No If "Yes", please enter effective date of termination _____

PLEASE COMPLETE FOR PERSONS TO BE INSURED

(Use additional paper if needed.)

Choose Plan(s):				Name (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Actively At Work*
Accident	Cancer	Hospital	Dental					
					Employee			☐ Yes ☐ No
					Spouse			☐ Yes ☐ No
								N/A
								N/A
								N/A

*Actively at work means that he/she is actively at work now for wage or profit and has worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy.

Premium/Billing Mode
☐ Monthly ☐ Semi-monthly ☐ Bi-weekly
☐ Weekly ☐ Other

Date of Issue _____

Case Number	Agent Number	Percentage Credit
Employee Number		
Situs State		

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

SELECTION OF COVERAGE SECTION

(Answer Yes or No and complete for each coverage selected)

Accident ☐ Yes ☐ No	Base Units _____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Optional Disability Riders for Employee ☐ Off the Job Accident ☐ Off the Job Accident and Sickness ☐ On and Off the Job Accident ☐ On and Off the Job Accident and Sickness	Employee Monthly Salary $ _____	Rider Units _____
Optional Disability Riders for Spouse ☐ On and Off the Job Accident for Insured Spouse* ☐ On and Off the Job Accident and Sickness for Insured Spouse* ***Available only when Employee + Spouse or Family coverage is selected and the insured spouse has worked 25 hours per week for 3 or more consecutive months.**	Spouse Monthly Salary $ _____	Rider Units _____

Cancer/Specified Disease ☐ Yes ☐ No **(GVCP3)**	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital	Radiation / Chemotherapy	Surgery Related	Misc.	Cancer Initial Diagnosis Option ☐	Intensive Care Option ☐	Wellness Benefit Option ☐
Units				1			

Hospital Indemnity ☐ Yes ☐ No	Plan _____	☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Benefits	Hospital Related	Surgery / Inpatient Physician	Outpatient Related	Diagnostic / Wellness Option ☐	Prescription Drug Option ☐	Disability Rider ☐	Life Rider ☐
Units						1	

Heritage Choice Dental ☐ Yes ☐ No	☐ Plan 1 ☐ Plan 4 ☐ Plan 2 ☐ Plan 5 ☐ Plan 3	☐ Employee Only ☐ Employee+One ☐ Family	Section 125 ☐ Yes ☐ No	Total Mode Premium $ _____

Were you covered under your Employer's prior Dental Plan? ☐ Yes ☐ No

If "Yes", please enter the date coverage effective _____

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM
EVIDENCE OF INSURABILITY SECTION

(Please complete each question applicable to coverages selected. Does not apply to Dental.)

If any of the questions 1-6 below are answered "yes", please list the required health history on the next page.		
Cancer, Hospital Indemnity & Sickness Disability Riders	1. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or ever tested positive for antigens or antibodies to an AIDS virus?	☐ Yes ☐ No
Sickness Disability Riders	2a. Has any person to be insured, within the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's Disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas or back; paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke?	☐ Yes ☐ No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
	c. Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse?	☐ Yes ☐ No
	d. Has any person to be insured had any medical or surgical procedures (including organ transplant) advised or recommended by a doctor but not done at this time?	☐ Yes ☐ No
Cancer & Hospital Indemnity	3a. Has any person to be insured ever been diagnosed with or treated for any type of cancer, other than basal cell skin cancer?	☐ Yes ☐ No
	b. If the answer to the above question is yes, has any person to be insured ever been diagnosed with or treated for leukemia, Hodgkin's disease, lymphoma or cancer with any lymph node involvement or more than one metastasis?	☐ Yes ☐ No
	c. Has any person to be insured been diagnosed with or received treatment for any cancer (other than those listed in the above question and/or basal skin cancer) during the past 5 years?	☐ Yes ☐ No
Cancer	4. Has any person to be insured ever been diagnosed with or treated for amyotrophic lateral sclerosis, muscular dystrophy, multiple sclerosis, encephalitis, tetanus, tuberculosis, osteomyelitis, cerebrospinal meningitis, brucellosis, sickle cell anemia, thallasemia, rocky mountain spotted fever, legionnaire's disease, Addison's disease, Hansen's disease, tularemia, hepatitis (Chronic B or Chronic C with liver failure or hepatoma), typhoid fever, myasthenia gravis, Reye's syndrome, primary sclerosing cholangitis, Lyme disease, systemic lupus erythematosus, cystic fibrosis, or primary biliary cirrhosis?	☐ Yes ☐ No
Intensive Care Option (Cancer Only) & Hospital Indemnity	5a. Is any person to be insured now being treated for, or ever been treated for: a stroke; a heart attack; a heart condition; heart trouble; or any abnormality of the heart (including artery disease)?	☐ Yes ☐ No
	b. Has any person to be insured, in the last year, been diagnosed with hypertension or high blood pressure, and in the last year had either a systolic blood pressure reading higher than 150 more than once; or had a diastolic blood pressure reading higher than 100 more than once?	☐ Yes ☐ No
Hospital Indemnity	6. Has any person to be insured, within the last 3 years, been treated for, or been told by a member of the medical profession that he or she has: epilepsy; hepatitis; muscular dystrophy or multiple sclerosis or any disorder of the central nervous system; Parkinson's Disease; lupus; any disorder of the kidneys, liver, lungs; paralysis; been counseled for alcohol or drug abuse; or had any medical or surgical procedure recommended but not done at this time?	☐ Yes ☐ No

EVIDENCE OF INSURABILITY AND ENROLLMENT FORM

REQUIRED HEALTH HISTORY

***Include diagnosis, dates, and duration along with names and addresses of all attending physicians and medical facilities.**

PERSON	REASON Nature of any illness, injury, or diagnosis	DATES Including duration of illness	NAMES AND ADDRESSES OF HOSPITALS AND/OR PHYSICIANS

Use this space for any additional explanation of questions 1-6 on page 3. Indicate the applicable question number and person to whom it applies. Use additional paper if needed.

CERTIFICATION, UNDERSTANDING AND AUTHORIZATIONS

I CERTIFY that the statements and answers provided are made by me, are complete and true, are correctly and fully recorded and that no important circumstance or information has been withheld or omitted. These statements and answers are offered to AHL as an inducement to grant insurance, and I understand that AHL may use misstatements or misrepresentations to contest the validity of any coverage provided on the basis of this evidence of insurability. **FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.** · **I UNDERSTAND** that the "effective date" of my elected coverages will be the effective date recorded on the Certificate, not the date this form is signed. · **I AUTHORIZE** any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, or other organization, institution or person, that has records or knowledge of me or my health to give to American Heritage Life, it's subsidiaries or its reinsurers any information. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying American Heritage Life in writing of my desire to do so. · **I ALSO AUTHORIZE** my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Employee's Signature _____ Signed at _____ Date Signed _____
(City and State)

Allstate.
FINANCIAL

Workplace Division

April 11, 2002
NAIC No. 60534
FEIN No. 59-0781901

Arkansas Department of Insurance
Attn: John Shields
1200 W. Third Street
Little Rock, Arkansas 72201-1904

RE: Group Accident Forms GVAP1AR, et. al. as listed on attached List of Forms

Dear Mr.Shields:

The above referenced forms are being submitted in duplicate for your review and approval. These forms are new and do not replace any forms previously approved by your department. They will be solicited by agents licensed to do business in your state. These forms are used to issue group insurance to employer groups with more than 50 employees and were filed in Florida, our domicile state on April 3, 2002.

Material may vary, but will always be in accordance with your state laws. We have enclosed two listings of variable information for your convenience, which outline the variables for the policy and certificate.

The enrollment may be taken through electronic enrollment procedures by our licensed agents using a pen-based signature pad, PIN numbers, and any other valid electronic signature method. You have our assurance that appropriate encryption standards have been implemented to prohibit alteration of the application after the applicant has signed it.

Any logo, officer signature, Home Office address, or telephone number that appear on these forms is subject to change.

The following materials are included with this filing:

- If applicable, any special forms required in your state
- Any filing certifications and/or filing fees required by your state for this filing

If you have any questions, please contact me at (800) 521-3535, ext. 3046. I can also be reached by e-mail at scott.sprague@ahlcorp.com. Thank you for your consideration.

Sincerely,

Scott Sprague

Scott Sprague

Enclosures

American Heritage Life Insurance Company
1776 American Heritage Life Drive Jacksonville, Florida 32224-6688 Phone 904.992.1776

ACCIDENT PLAN
WHICH INCLUDES ACCIDENTAL DEATH AND DISMEMBERMENT
GROUP POLICY SPECIFICATIONS

POLICYHOLDER:	[XYZ COMPANY, INC.]
POLICY NUMBER:	[GROUP106]
POLICY EFFECTIVE DATE:	[May 1, 2010]
POLICY ANNIVERSARY DATE:	[May 1, 2011] and the [first] day of [April] each calendar year thereafter.
GOVERNING JURISDICTION:	the state of Arkansas and subject to the laws of that jurisdiction.

ELIGIBLE CLASS(ES): [All full-time active employees working at least [25] hours per week for [3] consecutive months, excluding employees who are insured under any individual accident policy through American Heritage Life Insurance Company.]

BENEFITS: See page 3A

OPTIONAL RIDER(S):
[Off the Job Accident Disability - $1,000 per month]
[On and Off the Job Accident Disability - $1,000 per month]
[Off the Job Accident and Sickness Disability - $1,000 per month]
[On and Off the Job Accident and Sickness Disability - $1,000 per month]
[On and Off the Job Accident Disability for Insured Spouse - $500 per month]
[On and Off the Job Accident and Sickness Disability for Insured Spouse - $500 per month]
[Accident Benefit Enhancement (1.00 unit) – See page 3B]

INITIAL RATE:
Monthly rate of [$XX.XX] per employee for Individual Coverage; or
[[$XX.XX] per employee for Individual and Spouse Coverage; or
[$XX.XX] per employee for Individual and Child(ren) Coverage; or]
[$XX.XX] per employee for Family Coverage.

RATE GUARANTEE DATE: [04/01/2003]

PREMIUM DUE: [04/01/2002] and the [first day] of each [calendar month] thereafter.
The policyholder must send all premiums on or before the premium due date to us. The premium must be paid in United States dollars.

COST OF COVERAGE:
[The employer pays the cost of the employee's coverage.]
[The employee and the employer share the cost of coverage.]
[The employee pays the cost of coverage.]

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES

These are the policyholder's divisions, subsidiaries, or affiliates listed below. The policyholder may act for and on behalf of any and all of these in all matters that pertain to this plan. Every act done by, agreement made with, or notice given to the policyholder will be binding on them.

Name	Location (City And State)
[None]	

Benefits	**Principal Amount**		
	Insured Employee	Spouse	Child(ren)
[Accidental Death	$20,000	$10,000	$5,000
Common Carrier Accidental Death	$100,000	$50,000	$25,000
Dismemberment (scheduled – maximum benefit)	$20,000*****	$10,000*****	$5,000*****
Dislocation/Fracture (scheduled – maximum benefit)	$2,000*****	$1,000*****	$500*****
Initial Hospitalization Confinement	$500	$500	$500
Hospitalization Confinement (daily benefit amount)	$100	$100	$100
Intensive Care (daily benefit amount)	$200	$200	$200
Ambulance Services			
Ground Ambulance	$100	$100	$100
Air Ambulance	$300	$300	$300
Medical Expenses	$250	$250	$250
Outpatient Physicians Treatment Benefit	$25	$25	$25]

***Multiplied by applicable factor on page [13].**

[ACCIDENT POLICY – GVAP1(AR)
GROUP ACCIDENT BENEFIT ENHANCEMENT RIDER – GVAPBER
SEE BENEFITS SECTION OF RIDER FOR DETAILS OF BENEFITS

	BENEFITS	AMOUNT
A.	HOSPITAL ADMISSION BENEFIT	[$500.00]
B.	LACERATIONS BENEFIT	[$50.00]
C.	BURNS BENEFIT	
	1. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN 15% OF THE TOTAL BODY SURFACE	[$100.00]
	2. SECOND AND THIRD DEGREE BURNS COVERING 15% OR MORE OF THE TOTAL BODY SURFACE	[$500.00]
D.	SKIN GRAFT BENEFIT	[50% OF BURN BENEFIT]
E.	BRAIN INJURY DIAGNOSIS BENEFIT	[$150.00]
F.	COMPUTED TOMOGRAPHY SCAN OR MAGNETIC RESONANCE IMAGING	[$50.00]
G.	PARALYSIS BENEFIT	
	1. PARAPLEGIA (PARALYSIS OF 2 OR 3 LIMBS)	[$7,500.00]
	2. QUADRIPLEGIA (PARALYSIS OF 4 LIMBS)	[$15,000.00]
H.	COMA WITH RESPIRATORY ASSISTANCE BENEFIT	[$10,000.00]
I.	OPEN ABDOMINAL OR THORACIC SURGERY BENEFIT	[$1000.00]
J.	TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY BENEFIT	
	1. WITH REPAIR	[$500.00]
	2. WITHOUT REPAIR	[$150.00]
K.	RUPTURED DISC SURGERY BENEFIT	[$500.00]
L.	EYE SURGERY BENEFIT	[$100.00]
M.	GENERAL ANESTHESIA BENEFIT	[$100.00]
N.	BLOOD AND PLASMA BENEFIT	[$300.00]
O.	APPLIANCE BENEFIT	[$125.00]
P.	MEDICAL SUPPLIES BENEFIT	[$5.00]
Q.	MEDICINE BENEFIT	[$5.00]
R.	PROSTHESIS BENEFIT	
	1. 1 DEVICE	[$500.00]
	2. 2 OR MORE DEVICES	[$1,000.000]
S.	PHYSICAL THERAPY BENEFIT	[$30.00/DAY]
T.	REHABILITATION UNIT BENEFIT	[$100.00/DAY]
U.	NON-LOCAL TRANSPORTATION BENEFIT	[$400.00/TRIP]
V.	FAMILY MEMBER LODGING BENEFIT	[$100.00/DAY]
W.	POST-ACCIDENT TRANSPORTATION BENEFIT	[$200.00]
X.	ACCIDENT FOLLOW-UP TREATMENT BENEFIT	[$50.00/DAY]

AMERICAN HERITAGE LIFE INSURANCE COMPANY
1776 American Heritage Life Drive, Jacksonville, Florida 32224

CERTIFICATE SPECIFICATIONS

FORM NO.	DESCRIPTION OF BENEFITS	NUMBER OF YEARS PAYABLE	ANNUAL PREMIUM AMOUNT
[GVAC1(AR)	Accident Coverage *** See Page 3A for Benefit Amounts ***	LIFE**	$00.00
GVACBER	Accident Benefit Enhancement Rider (1.00 Unit) *** See Page 3B for Benefit Amounts ***	LIFE**	$00.00
		TOTAL	$00.00

FAMILY COVERAGE

** SUBJECT TO TERMINATION OF COVERAGE PROVISION

The effective date and issue age of each benefit is the Effective Date unless otherwise specified.

TOTAL PREMIUMS

The Total Premiums include the charge for any additional benefits.

ANNUAL	SEMI-ANNUAL	QUARTERLY	MONTHLY	BILLABLE PREMIUM
$000.00	$000.00	$00.00	$00.00	$00.00

Premium Payment Method PAYROLL - MONTHLY

INSURED: JOHN DOE

BENEFICIARY: AS NAMED ON ENROLLMENT FORM

EFFECTIVE DATE: MAY 01, 2010 CERTIFICATE NUMBER: 123456

GROUP POLICY NUMBER: GROUP106]

Benefits	**Principal Amount**		
	Insured Employee	Spouse	Child(ren)
[Accidental Death	$20,000	$10,000	$5,000
Common Carrier Accidental Death	$100,000	$50,000	$25,000
Dismemberment (scheduled – maximum benefit)	$20,000*****	$10,000*****	$5,000*****
Dislocation/Fracture (scheduled – maximum benefit)	$2,000*****	$1,000*****	$500*****
Initial Hospitalization Confinement	$500	$500	$500
Hospitalization Confinement (daily benefit amount)	$100	$100	$100
Intensive Care (daily benefit amount)	$200	$200	$200
Ambulance Services			
Ground Ambulance	$100	$100	$100
Air Ambulance	$300	$300	$300
Medical Expenses	$250	$250	$250
Outpatient Physicians Treatment Benefit	$25	$25	$25]

*** Multiplied by applicable factor on page [12].**

[ACCIDENT CERTIFICATE – GVAC1(AR)
GROUP ACCIDENT BENEFIT ENHANCEMENT RIDER – GVACBER
SEE BENEFITS SECTION OF RIDER FOR DETAILS OF BENEFITS

	BENEFITS	AMOUNT
A.	HOSPITAL ADMISSION BENEFIT	[$500.00]
B.	LACERATIONS BENEFIT	[$50.00]
C.	BURNS BENEFIT	
	1. SECOND AND THIRD DEGREE BURNS COVERING LESS THAN 15% OF THE TOTAL BODY SURFACE	[$100.00]
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E.	BRAIN INJURY DIAGNOSIS BENEFIT	[$150.00]
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J.	TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY BENEFIT	
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K.	RUPTURED DISC SURGERY BENEFIT	[$500.00]
L.	EYE SURGERY BENEFIT	[$100.00]
M.	GENERAL ANESTHESIA BENEFIT	[$100.00]
N.	BLOOD AND PLASMA BENEFIT	[$300.00]
O.	APPLIANCE BENEFIT	[$125.00]
P.	MEDICAL SUPPLIES BENEFIT	[$5.00]
Q.	MEDICINE BENEFIT	[$5.00]
R.	PROSTHESIS BENEFIT	
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U.	NON-LOCAL TRANSPORTATION BENEFIT	[$400.00/TRIP]
V.	FAMILY MEMBER LODGING BENEFIT	[$100.00/DAY]
W.	POST-ACCIDENT TRANSPORTATION BENEFIT	[$200.00]
X.	ACCIDENT FOLLOW-UP TREATMENT BENEFIT	[$50.00/DAY]